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INTERNATIONAL REVIEW OF THE RED CROSS

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INTERNATIONAL REVIEW OF THE RED CROSS

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Editor: J.-G. LOSSIER

Nursing Problems

The Nurse-Patient Relationship

by S. Raine

Nursing care and the very function of nursing is the more susceptible to change today that the concept of health and the medical needs of the individual and of society have considerably altered. As the Director of the French Red Cross Ecole des Cadres *has pointed out,*[1] *the duties of the nurse are no longer merely the technical aspects of care, such as bandaging, administration of injections, and so forth, but include responding to all human health needs. Hence, one of the major problems is still the relationship between the nurse and the patient. When this is realized, one better understands the original nature of nursing, for a question underlying the nursing vocation is : " is that relationship an end or a means to an end? ".*

The problem was recently studied in an article which we are pleased to be able to quote.[2] *(Ed.)*

The word " relationship " has for some time now become, in the nursing profession at least, one of those terms which, due to its indiscriminate use, has lost any specific meaning and has come to be just another colourless expression endowed with whatever meaning the user may choose to give it. It may be bandied about as a weapon or as a form of justification, and the emotional content with which it is loaded simply helps to aggravate mutual misunderstanding and to stress ideological differences.

[1] See Marie-Louise Badouaille, *Vie et Bonté*, the French Red Cross review, Paris, December 1970.

[2] Our thanks go to the editor of the *Revue de l'infirmière*, Paris, who has permitted us to quote this study which appeared in the January 1971 issue.

This word is, therefore, a problem. I intend, in this article, to begin with a brief review of the reasons which may have given rise to its rather unusual popularity, paying particular attention to relationship problems in hospitals. I shall tackle the subject of the pedagogical consequences suggested to me by the consideration of the meaning of the words " technique " or " technology " and " relationship ".

I think that it might be as well if I were to destroy some of the myths that surround the word " relationship " for, regardless of the meaning that various people may give it, it is significant that in most countries the nursing profession has always had to consider how to give a number of acts, aimed at meeting the needs of the sick, some kind of sense. These acts have lost some of their meaning because of a number of factors that we shall quickly consider.

Various studies of communication have shown that when two persons happen to be together, they cannot fail to communicate. Not only does everything boil down to communication, e.g. words, gestures, silence, but we even communicate about the communications that pass between us, a process which some authors have called metacommunication.[1] Hence, the same reproach made with a frown or with a smile would mean two entirely different things. Animals, too, make metacommunication. Cats, for example, can give out any number of battle signs while keeping their claws sheathed. By such metacommunication, the cat informs other cats, and humans too, that it is not really fighting but just pretending to fight.

What, therefore, are we communicating to the patients in our care that makes them voice so much dissatisfaction, while the technical side of the care we give is constantly improving? To listen to the complaints that are made, it would seem that the main point is that the patient does not feel that he exists as far as the nursing staff is concerned and that he rarely feels that he is in the presence of a real person. This mutual feeling of depersonalization, of being a thing manhandled by another thing, is most unpleasant. This

[1] Metacommunication: a commentary on the literal content and on the nature of the relationships between the persons involved. This is a message within a message. SATIR (Virginia). Conjoint Family Therapy, Science and Behavior Books, 1964, p. 76.

phenomenon is not, however, limited to nurse-patient relationships, but can frequently be found in everyday life.

The fear of becoming involved, of discovering oneself, of allowing one's emotions to sympathize with those of another as well as the unwillingness to force oneself on another, to appear indiscreet by showing interest in events concerning the personal life of another, are all very general. Moreover, the erection of walls of insulation even between close relatives is becoming increasingly frequent, and it goes without saying that this process of mutual reserve leads to ever more summary relationships in all circumstances. Nowadays, if we enter into relationship with another person, it is only for a precise reason which, in a way, explains and excuses our audacity in penetrating his private life. As counterpart, the rules of the game demand that we should not overstep the limits that this summary encounter may authorize and that we should not stray from the purpose for which the encounter was made. It is but a short step from this to a confusion between man and thing. " You have come to me to have your broken foot cared for, so I am caring for your broken foot (and not you)."

Why is it becoming increasingly difficult to communicate and to become involved? The answer to this question would be outside the scope of this article. In his book " Le Petit Prince ", St-Exupéry may have touched on one of the obstacles to the establishment of " links " from which we may suffer. The question is, can nurses, who live in constant contact with suffering and death be humanly expected to strike up relationships demanding their own personal involvement? Such relationships will always be broken by either separation or death. A sociologist would no doubt suggest some other origin to this difficulty. But let us see what other factors, in hospitals at least, might further accentuate this feeling of depersonalization in personal relationships—and especially in those developing between nurses and patients, as that is the subject which concerns us here.

I shall certainly not be the first to recall the different aspects which have already had, and which in future will probably continue increasingly to have, a depersonalizing influence on the quality of the relationships likely to develop between patients and nurses in hospitals. Upon writing the words " patients " and " nurses ",

I realize how difficult it is for me to put them in the singular as though the very thought that a patient might consider a nurse as being " his " particular nurse were already inconceivable in the existing hospital system.

This dehumanization is, in fact, an inescapable trend which, if we are not careful, may well have an irreversible influence on the quality of human contact in our hospitals and in the various organizations responsible for improving the health of our communities.

This trend is the result of many factors and I shall mention here only those which strike me as being the most powerful:

— the increasing use of various techniques calling for the manipulation of large numbers of objects and complex machines;

— the progressive industrialization of administrative and organizational working methods which break down the tasks in such a way that the nurse is simply left with the job of " caring for " the patient. Besides, this function of " caring for " is restricted to those tasks which call for a high level of qualification, and the tasks requiring a lower degree of qualification are left to less skilled persons;

— specialization, which is so characteristic of our age, is not the prerogative of the doctors; nurses working with them are also prone to certain professional deformations leading to a fragmentary perception of patients; this, in turn, means that instead of seeing a patient they only see a bit of him, such as a hip, a breast, an eye, a lung, a heart, or even just the illness with which that part of the patient is affected;

— different therapeutic concepts and the high cost of hospitalization have resulted in ever shorter stays in hospital which considerably reduce the possibility of patients and nurses getting to know more of each other;

— likewise, with similar consequences, the decrease in working hours, also, is a cause of difficulties in the establishment of personal relationships between nurses and patients;

— another factor is the relatively more serious nature of the diseases from which hospitalized patients are suffering. In fact,

persons with the milder sort of ailments do not ask to be admitted to hospital as frequently as was the case in the past, for home care is now better organized. The result of this development is that there is a proportionately higher death rate than there used to be. So nurses, being more frequently confronted with the spectacle of death, may tend to nurture a more defensive attitude which manifests itself in a less personal relationship.

Why, under such conditions, should we persist in our efforts to persuade nurses to make greater contact with their patients? We may well ask. Is it a realistic attitude to hope to find once again in the technical and ever more anonymous environment of the hospital world, the warmth that we are told was so characteristic of nursing relationships of old? If we are satisfied to consider this relationship as the fruit of the nurse's innate qualities, then it should suffice to remind her, on her arrival at nursing school, that the patient must be heard and helped, and, as a result, she would spontaneously be able to strike up and maintain a relationship with all her patients. Such a view is obviously pure utopia. A river does not flow uphill. In the same way as we would advise a person, swept along by the current and in danger of drowning, to allow himself to be carried downstream by the current and to apply his efforts to reaching the shore, albeit far downstream, so it is essential that we should not struggle against the progress of technology. In this matter of relationships, as in others, let us use first principles. Let us study the basic aspects of these relationships in order to understand how they work and then let us apply them in practice for the greater satisfaction of both the nurse and the patient.

As with a pendulum at the start of its swing, we seem to be oscillating between extremes. One is that nursing consists basically of a number of precise techniques that the nurse must learn to carry out while understanding why she is doing them. The other aims at reducing as far as possible the practical in-hospital training part of nursing courses, in order to concentrate more on the theories underlying the tasks that the nurse will be called on to carry out. For some of us, the word " technology "[1] has almost become dis-

[1] Translator's note: the French word used here is " technique".

reputable. Technology is held responsible for all the ills of which the modern world is accused, and the hospital situation is naturally just one aspect of this. For some years now, many efforts have been made to reject the modern world and to return to a way of life more directly in contact with nature, thereby avoiding the use of machines (Fouriéristes, Gandhi, Laza del Vasto, Hippies).

What, then, is the meaning of the word " technology " so highly praised by some, yet so decried by others? This is what Littré's Dictionary of the French Language has to say: " Relating to an art; belonging to an art. Technical terms (*termes techniques*): terms specific to a given science or to a given art. Technical rhymes (*vers techniques*): rhymes containing the expression of some rule. Technology, the material part of an art. The totality of processes which together make an art." [1]

If nursing uses techniques, it is an art with rules and processes which are specific to it and it has its own vocabulary. Do we, in this case, need to compare " relationship " and " technology " in this art — nursing? Could we not consider that the professional relationship is nothing but one of those techniques proper to the art of nursing, a technique which is not an end in itself but one which enhances the quality of nursing care in its entirety as it is lavished on the patient? Taken from this point of view, the nurse-patient relationship could become the centre point of that collection of rules and processes proper to the art of nursing for it could be considered as the very axle around which this art revolves.

How can we give the relationship this central function? To start with, let us return once again to our study of the true meaning of the word for it has been given such emotional undertones that it is impossible to use it without qualifying it with a mass of unvoiced adjectives such as full, good, deep, warm, excellent, positive, and so forth, and this means that any relationships which cannot match up to these qualities bestow a feeling of guilt for they are tantamount to failure.

Now if we consider the definition of the word " relationship " as given in Littré, we find: " the state existing between one thing and another. In philosophy, it is the situation existing between

[1] Dictionnaire de la langue française, abrégé du dictionnaire Littré par A. Beaujan, Gallimard et Hachette, 1959.

two persons or between two things considered in respect of each other. Liaison, commerce, correspondence. Or the persons themselves with whom one has a bond. In anatomy: the respective position of the parts as regards other parts (and finally, account, narration of an occurrence or of an event) ".[1]

Let us take a close look at the key words and ideas in these definitions. These are: the state existing between one thing and another, the situation existing between two things considered in respect of each other and finally (the additional French meaning of) the accounting or narration of an occurrence. These are the terms that we should bear in mind in order to be able to divest from the word " relationship " its qualitative shades of meaning and to restore to it those characteristics, most appropriate to the role as a sustaining element in nursing, which we should like to give it.

The relationship will therefore have to be formed to allow each of the two persons brought together—the nurse and the patient—to envisage each other in respect of their mutual rapport. The nurse does not, in fact, seek, as a person of good will concerned with the state of isolation and suffering of another, to form a relationship, but rather as a person whose function it is to care for another. To attain this, the nurse holds that it is necessary to know the needs of the patient, needs which are best expressed by the patient himself as it is he who is most directly concerned. For greater apparent efficiency, the nurse can no doubt deduce some of the patient's needs and gather a number of items of information without having to strike up a relationship, e.g. she will have a general idea about the patient's illness, she will have his case file and be able to make her own observations, etc. In this case it would, however, be more exact to say that it is from the disease that the nurse has identified the needs. For no one else can express the needs of a particular patient as a " person " with his own past, present and future, unless it is the patient himself who experiences such needs.

Consequently, in our concern for technical efficiency, we feel it necessary to prepare student nurses to establish and use their relationships with the patients, for it is this that will allow the nurse

[1] Translator's note: the French use the same word " relation " where in English we use " relation ", " relationship " and " relating ".

to play her role to the full, and that will enable her to develop and to find satisfaction in her chosen career. Nursing cannot remain a mere collection of " material components " of the art of caring for the sick, divided into a number of tasks such as inoculating, dressing wounds, making beds, washing the patient, administering medicaments, and so forth. This is but mass production as conjured up by the title of the book by Georges Friedman " Le Travail en Miettes " (Piecemeal work). A friend of mine who was recently admitted to a hospital told me that he had counted the number of people who had come into his room between the time he woke up and 8 a.m. There had been 18. One opened the shutters, another came to say " good morning " and to glance at his temperature graph, another took his pulse; then came others to take his; temperature, give him his washing things, distribute the bed-pans, empty them, wash the bed-ridden patients, make the beds of those who are mobile while others again make the beds of those who cannot move; and then followed others distributing medicaments, drinks and so forth.

This example shows clearly how great is the need for nurses to rethink their nursing methods. Should we continue viewing the problem through the wrong end of the telescope and try to perfect each act, whilst admitting that such acts are fleeting moments of contact between the nurse and the patient? To make a relationship depend on an act which has to be performed when, in fact, such acts are executed by so many different people and when they are scattered over so many isolated seconds and minutes which are so parsimoniously distributed among the patients, is neither conducive nor encouraging to speaking or listening; it is simply deluding ourselves on what to expect from this relationship. Is this the act of charity proferred to the patient, the smile or friendly word which clears the conscience and, at best, helps a little to break the anonymity of hospital life, or, on the other hand, is it the very core, the axis around which the many tasks of nursing revolve and on to which each individual nursing plan can be built? Such a plan could be built up from the sum of the information about the patient, gleaned from various sources. In such a case, the patient plays an active role as a participant in the nursing plan. He will no longer be a dependent and subjected individual, knowing nothing of the treat-

ment of which he is the object and to which he delivers himself with that agonizing and humiliating feeling that, from the moment he enters a hospital, he loses the right to speak, that he is no longer considered as an adult, or even as a person pure and simple, but as nothing more than an object, a patient who is troublesome and demanding as soon as he opens his mouth, as opposed to the " good " patient who never says a word.

If we are to take this point of view of the relationship, considering it to be a basic element of nursing, the element which gives nursing its meaning and its oneness, then a large part of nursing training syllabi must be devoted to studying and learning the techniques involved. Let us remember that there are no techniques without art, but that there is no art without technology.

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INTERNATIONAL COMMITTEE OF THE RED CROSS

EXTERNAL ACTIVITIES

Japan

The second phase of the operation for the repatriation of Koreans from Japan, begun on 11 May 1971, under the auspices of the Red Cross Societies of Japan and of the Democratic People's Republic of Korea, is going ahead. As already announced in our last issue, the first ship taking repatriates left Niigata on 14 May with 204 persons on board.[1] A second ship sailed on 18 June taking 58 families, a total of 169 persons.

Khmer Republic

Medical advice.—Dr. Werner Hinden, Doctor-Delegate of the ICRC in the Khmer Republic, has set up an additional programme for providing medical advice in various refugee centres in Phnom-Penh. These sessions have been made possible thanks to the loan of a medical vehicle by the Khmer Ministry of Health.

Dr. Hinden thus went, from 16 June, to the Léan Iv, Chrui-Changwar, Chat-Kâng and Lu-Ban-Hap centres and to the one set up in the sports ground complex; he examined an average of about 50 patients at each visit.

Distribution of relief.—On 14 June 1971, the Doctor-Delegate of the ICRC in the Khmer Republic was present, together with a representative of the League of Red Cross Societies, at a distribution of relief supplies provided by the Khmer Red Cross and organized by its President, Mrs. Chuop-Samloth. A donation was

[1] *Plate.*

presented first to the military hospital where the distribution was made; then mosquito nets, blankets, mats and food were given to refugees from Oddâr Méanchey.

Republic of Vietnam

Delegates and doctor-delegates of the ICRC in the Republic of Vietnam visited the prisoner-of-war camp of Phu-Quoc from 17 to 22 May 1971. On 14 June, they went to the prisoner-of-war camp at Danang, where they saw the thirteen prisoners of war prepared to take advantage of the release offer made on 4 June last to return to the Democratic Republic of Vietnam.

In the course of these two visits, the delegates talked, without witnesses, with prisoners of their own choice.

Bulgaria

On the occasion of the Fourth International Festival of Red Cross and Health Films held in Varna from 21 to 30 June 1971 [1], the President of the ICRC, Mr. Marcel A. Naville, went to Bulgaria at the invitation of the Bulgarian Red Cross.

Mr. Naville, who was accompanied by Mr. Alain Modoux, Head of the Press and Information Division, was welcomed by the President of the Bulgarian Red Cross, Dr. Kiril Ignatov, and by the First Vice-President, Mr. Gueorgui Gospodinov. During his stay in Bulgaria, Mr. Naville visited the National Society's headquarters in Sofia and various regional committees, including that of Varna. The ICRC President was also received by Mr. Gueorgui Traikov, President of the People's Republic of Bulgaria, and by Mr. Ivan Bachev, Minister for Foreign Affairs.

Near East

Visits to prisoners of war

ICRC delegates in Israel, the occupied territories, and the United Arab Republic, visited prisoners of war. As customary,

[1] An article on the Festival is given elsewhere in this issue.

they talked in private with the detainees of their choice and the reports on the visits are sent by the ICRC to the Detaining Power and to the detainees' own government.

In Israel and occupied territories, the ICRC delegates, on 1 July, visited a Syrian prisoner in a hospital where he was being treated for his wounds.

On 6 July 1971 they visited all the prisoners of war in Israeli hands at the Sarafand military prison, i.e. 75 from the United Arab Republic, 40 from Syria and 1 from Jordan.

In the United Arab Republic, the delegates visited the nine Israeli prisoners of war at the military prison of Abassieh on 28 June. The following day they went to see the two Israeli prisoners in a Cairo hospital for treatment of their wounds.

In addition, it should be mentioned that able-bodied Israeli prisoners of war went on a sight-seeing tour of Cairo and its outskirts in June.

Visits to Arab Civilian Detainees

The 14th and 15th series of prison visits in Israel and the occupied territories took place from 1 February to 15 March and from 22 March to 10 May 1971. The ICRC delegates went to 13 places of detention during the 14th series of visits, in which they saw nearly 3,000 Arab prisoners, and to 15 places of detention during the 15th series, when they saw more than 3,800 Arab prisoners. The ICRC delegation organized bus transport for families unable to afford the trip to the prisons to visit their detained relatives. In February, 80 buses took more than 5,000 persons to see 1,653 prisoners; in March, 60 buses took 3,800 persons to see 1,295 detained relatives.

In addition, 1,242 parcels were distributed in April and May by the ICRC to detainees who had not been visited by their families for three months. The parcels contained fruit, biscuits, cigarettes and soap.

The delegates interviewed the detainees of their own choice without witnesses. Their reports are sent to the detaining authorities.

Repatriation

On 18 June 1971 an Israeli civilian was repatriated from the Lebanon. Four days later, a Lebanese civilian was sent back from Israel to his country. These two operations took place under ICRC auspices.

Yemen Arab Republic

Two Yemeni technicians from the ICRC artificial limb workshop in Sana'a left on 6 July for Tehran. Thanks to grants from the Red Lion and Sun and from Oxfam, these two Yemenis will follow a 6-month course at the International Training Centre for Technical Orthopaedics run by the Iranian National Society.

Their training should enable them subsequently to assume responsibility for the production of artificial limbs and equipment for the disabled.

India and Pakistan

Mr. Victor Umbricht, member of the Presidential Council of the International Committee, and Mr. Jean Ott, ICRC Delegate-General for Asia, returned from the Indian sub-continent at the end of July.

In New Delhi, they met the President of the Republic of India, Mr. V. V. Giri, on 24 July. Two days later they were received by the President of Pakistan, General Yahya Kahn, who stated during their discussion that he viewed with favour a humanitarian operation by the ICRC in East Pakistan.

In both capitals, Mr. Umbricht met several government officials and National Society leaders who assured him of their support for the ICRC.

IN GENEVA

For Victims of Pseudo-Medical Experiments

The Neutral Commission appointed by the ICRC to decide on applications by Polish victims of pseudo-medical experiments in Nazi concentration camps during the Second War World met for the third time this year from 1 to 3 July 1971 at ICRC headquarters in Geneva. It consisted of Mr. W. Lenoir, President of the Neutral Commission and judge of the Geneva Court of Justice, Dr. S. Mutrux, assistant director of the Bel-Air psychiatric clinic of Geneva, and Dr. P. Magnenat, Dean of the Faculty of Medicine and assistant at the Nestlé Hospital university clinic at Lausanne.

The Neutral Commission awarded 80 victims whose claims were found to be justified indemnities totalling DM 2,160,000. The assistance paid by the Government of the Federal Republic of Germany to Polish victims of pseudo-medical experiments up to 4 May 1971, the date of the Neutral Commission's previous meeting, came to DM 31,070,000 (and not DM 28,540,000, as had been indicated by mistake in our June issue). The Neutral Commission's latest award brings the total of the indemnities paid by the Bonn Government to DM 33,230,000.

ICRC Relief Action

On 14 June the ICRC Relief Service despatched by air 20 first-aid kits to the Sudan Red Crescent Society and 5 to the Togolese Red Cross.

On 28 June medical supplies of vitamins and antibiotics, quinine and other products to a value of nearly 5,000 Swiss francs left Geneva for Ecuador. The consignment is intended for prisons in that country following the last series of visits carried out by the ICRC.

On 25 June, through its delegate on the spot, the ICRC forwarded three surgical kits to the Neo Lao Hak Sat (Pathet Lao) representative in Vientiane.

Repatriation of Koreans from Japan

Niigata, Japan: Departure in May 1971 of the ship sailing to the Democratic People's Republic of Korea (*right*, Miss Casal, ICRC delegate).

Arrival of Koreans in Niigata for repatriation.

December 1959 : The start of repatriation of Koreans resident in Japan

Embarking at Niigata.

An ICRC Delegate in Ceylon

Following the events in Ceylon, the International Committee of the Red Cross sent, from 27 April to 12 June 1971, its delegate, Mr. Roger Du Pasquier, who visited there hospitals and places of detention containing respectively the wounded and injured and persons under arrest.

As already stated in our issues of June and July, Mr. Du Pasquier travelled all over the island, accompanied by government officials and members of the National Red Cross Society, and made distributions of relief to detainees. He brought back an interesting record of his mission, in the form of travel jottings, which we give below.

When the two men wearing the red cross emblem entered the newly established camp at Anuradhapura, in the north central region of Ceylon, they were greeted with wide smiles by the detainees who recognized the two visitors, whom they had already seen in their previous place of detention, on the university campus of Vidyodaya near Colombo.

The two Red Cross representatives were the Chairman of the Ceylon Red Cross and the delegate of the International Committee. They had together visited a good number of places of detention and hospitals containing the victims of the events which had so brutally shaken Lanka, the " splendorous isle ", during the first half of April.

This time, at Anuradhapura, the ancient capital of a prosperous kingdom and now a centre of pilgrimage for Buddhists, and a vast field of research for archaeological remains, the two Red Cross men had not only come to verify for themselves that the conditions of detention met humanitarian requirements. They also brought with

them a consignment of relief urgently needed by the 500 inmates of this newly established " rehabilitation " camp, as it was called. These supplies included light vests, suitable for tropical wear, and a good-sized piece of cloth from which shorts were to be made, thus allowing the young detainees to avoid wearing out their sarong —that graceful item of clothing which the inhabitants of Ceylon wear tied round their hips and which covers all the lower part of the body down to the feet.

The visitors had added to these priority items some games and sports equipment so that the detainees might have something to do to occupy and amuse themselves during their hours of leisure. There were balls and nets for volley-ball, draughts and " carrom-boards ", the latter being a kind of small-scale billiard game where discs take the place of balls. As these gifts were unpacked by a few of the detainees, there was a burst of applause from their comrades. They had passed a week of enforced idleness during their temporary stay at Vidyodaya where conditions had been very monotonous. They had not even enjoyed any entertainment comparable with the one offered every day to those detained in the old prison of Anuradhapura (soon to be demolished), and who witnessed the antics of the apes which came in from the jungle just outside, and which no barrier erected for human beings could keep out.

* * *

The ICRC delegate had arrived in Colombo shortly after the island of Ceylon, which had been for so long a land of peace and beauty, had become the scene of strife and bloodshed in a conflict that had taken most of its inhabitants completely unawares. The uprising had shaken nearly all areas, leaving hundreds dead and wounded. Hospitals were filled to overflowing and lacked medicaments, mainly antibiotics, and there was a shortage of blood plasma and surgical material. The Government of Ceylon sent appeals for aid to the international community, which, it must be said, was not too well informed of the harsh facts of the dramatic events lived out on the island.

The delegate's first task was to investigate the extent of the needs, and he endeavoured, too, to find out how far the Red Cross

world would be able to meet them. At the same time, he sought to offer that specific aid which only the ICRC can bring to that category of victims, in this case very numerous, consisting of persons arrested by reason of the conflict.

Accompanied by Mr. Samaranayaka, Chairman of the Ceylon Red Cross, the delegate first visited the hospitals in Colombo, where quite a number of the wounded were being cared for. His request for authorization to visit also wounded and sick rebels was immediately granted, and he was thus able to go to the prison infirmary where there were about 80 patients.

These hospital visits were continued in the different regions of the island, in the first place in those most seriously affected by the events. Transport employed was sometimes by helicopter but more often by road. The tropical vegetation was of incomparable beauty, but its very luxuriance provided at the same time conditions ideal for guerrilla warfare. Traffic was frequently slowed down by the remains of road-blocks erected by the rebels to delay the progress of government troops, or by damage caused to many of the bridges, which, in most cases, though, had not been completely destroyed. Everywhere, the country was seeking to recover from the disturbances through which it had passed, and the red cross emblem was welcomed as a good omen.

Though the number of wounded among both security forces and rebels did not appear to be excessively high, medical services on the other hand had been quite seriously disorganized by the events. In some areas, for instance in the Kegalle region, on the road linking Colombo and Kandy, the state of insecurity for several weeks prevented civilians from going to district hospitals for treatment, and the population suffered considerably from this.

* * *

These rounds of visits provided the Chairman of the Ceylon Red Cross and the ICRC delegate with opportunities to see rebels captured by security forces, notably those held in prison infirmaries. They were thus able to see for themselves that the large majority of those who had taken part in the attempted revolt were young men between 18 and 25 years old. Some were younger still, not

much older than mere children. Their presence in large numbers within places of detention gave rise to serious social and humanitarian problems.

As the weeks passed by, the number of detainees rose, because the rebels, in response to government appeals, often consented to give themselves up against the assurance of being treated liberally. Prisons were soon overcrowded and, in order to relieve the pressure, the authorities set up internment camps on the university campuses of Vidyodaya and Vidyalankara, near Colombo. The ICRC delegate went to these camps and examined with the authorities a programme of humanitarian aid to the internees. In this way, thanks to credits made available to its delegate by the ICRC in Geneva, he was able to provide young detainees with clothing, a need that began to be felt particularly acutely.

In agreement with the Ceylon authorities, the ICRC will continue to furnish assistance to persons detained because of the recent uprising and will be allowed to visit them at regular intervals. It has already organized the despatch of further relief, especially of medical supplies, for the benefit of the persons placed under its protection and who, in the jungles of Ceylon, have just added another particularly dramatic chapter to the long story of the revolt of the young in the world of today.

THE "SOLDIER'S MANUAL"

It is common knowledge that the ICRC, in order to make the humanitarian Red Cross principles known throughout the world, has produced a school textbook entitled *The Red Cross and My Country*, followed by a *Teacher's Manual*.[1] It has already been issued in fifteen languages. More than a million copies have been printed and it has been distributed in schools in fifty-five countries.

Subsequently, it appeared necessary to publish also a handbook for officers and other ranks of the armed forces. It was entitled the *Soldier's Manual*. Its inspiration was the same as that underlying the school textbook. However, while the latter is designed to inculcate in schoolchildren, by means of short illustrated texts, the principles of the Red Cross and of humanitarian law, the *Soldier's Manual* summarizes the rules of the Geneva Conventions which should be applied in all circumstances when armed conflict breaks out.

*

The first edition in 1969, of which only 5,000 copies were printed [2], was designed first and foremost to arouse interest and to find out how governments to which the ICRC sent it reacted. Reception having been very favourable, especially from the ministries responsible for the armed forces, and in order to meet the wishes of various officials (35 countries conveyed to the ICRC their approval of the pilot edition), the second, pocket book edition, has just been printed, containing 24 pages of clear and concise text and designs with explanatory comments. It can be easily adapted to the needs of the countries and armies in which it has been introduced.

But wherefore a *Soldier's Manual*?

The 400 articles of the 1949 Geneva Conventions are known only to specialists, and strangers to international humanitarian

[1] See, *inter alia*, *International Review*, March 1971.

[2] After a mission by Mr. Jean-Marc Laverrière to more than a score of countries in Africa, and after being requested by Chiefs of Staff and officials responsible for defence in a number of countries.

law like soldiers, cannot easily assimilate them. The ICRC has, therefore, in addition to a *Summary of the Geneva Conventions of 12 August 1949*, which is for the public and armed forces but not illustrated, drawn up and had printed the *Manual* which, as already said, contains a summary of the essentials of the four Geneva Conventions, and in which an attempt has been made to make clear those aspects of humanitarian law which are deemed to be the most important.

In June 1971, 150,000 copies (in French 33,000, in English 33,000, in Spanish 33,000, and in Arabic 50,000) [1] came off the press. The Ministries of Defence and of Foreign Affairs of all countries which are parties to the Geneva Conventions, and all recognized National Societies, have received three copies, accompanied in some cases by a questionnaire. When these are all returned, the ICRC will know the opinions and requirements of the governments and will be able to decide on future run-offs.

The price of the *Manual* is Sw. Fr. 0.50 a copy. With a view to encouraging its dissemination and use by the armed forces, the ICRC is prepared to give a number of copies free of charge to authorities which are interested. In addition, the ICRC recommends the translation into local languages, at the discretion of Ministries of Defence. Some countries have already advised the ICRC that they intend to have the *Manual* published at their own expense.

We would add that the 23 illustrations in the *Soldier's Manual*, like those in *The Red Cross and My Country*, are by Mrs. Agnes Molnar, and that this publication, of which we have just described the success, ends with the following significant words:

" SOLDIER DON'T FORGET !

Protect enemy wounded, sick and prisoners as you yourself would wish to be protected.
You too might one day be wounded, sick, unarmed or taken prisoner."

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[1] *Plate.*

IN THE RED CROSS WORLD

WORLD RED CROSS DAY 1972

World Red Cross Day was again a resounding success in 1972. Events, some of them most original, were organized and many National Societies associating in this commemoration day did so for the first time. We have already said how various radio and television stations broadcast items for the occasion, and the material which was prepared was widely used.

However, it is already time to look ahead to the next World Day, and the League has informed us that the theme just chosen for it is:

Red Cross, Humanity's Bridge.

INTERNATIONAL RED CROSS MUSEUM

We have on several occasions drawn our readers' attention to exhibitions at the International Red Cross Museum in the pleasant Longhi Palace at Castiglione delle Stiviere and containing interesting documents and items relating to Red Cross history.[1] The many tourists in that part of northern Italy would find it well worth a visit, particularly for the exhibition being held there this year on " Natural Disasters and the Red Cross ".

Organized by the League of Red Cross Societies, and officially inaugurated on 25 June by Dr. Adalberto Galante, Commissioner of the Italian Red Cross, the exhibition shows, through photographs, graphic designs and texts, with sound effects and examples of equipment for disaster detection and relief, the causes and effects of natural disasters and the role of the Red Cross in bringing emergency care to the victims.

Volcanic eruptions, earthquakes, floods and drought, cyclones, typhoons, tidal waves, avalanches, landslides and their awesome destructive effects are vividly portrayed. In a section en-

[1] See, particularly, *International Review*, April 1962.

titled " Man helping man ", the role of the Red Cross in providing emergency care, shelter, food and clothing is described, and the phase of resettlement and reconstruction plus the important work of prevention and planning are illustrated.

The exhibition includes panels depicting a typical international relief action co-ordinated by the League, the world-wide network of relief supply warehouses, the co-operation between Red Cross and international agencies, particularly the United Nations. Among agencies which collaborated with the League in the creation of the exhibition are UNESCO, the World Meteorological Organization, the UN Food and Agriculture Organization (FAO), the Swiss Federal Institute for the Study of Snow and Avalanches, and Haroun Tazieff and his team of vulcanologists.

FOURTH VARNA FILM FESTIVAL

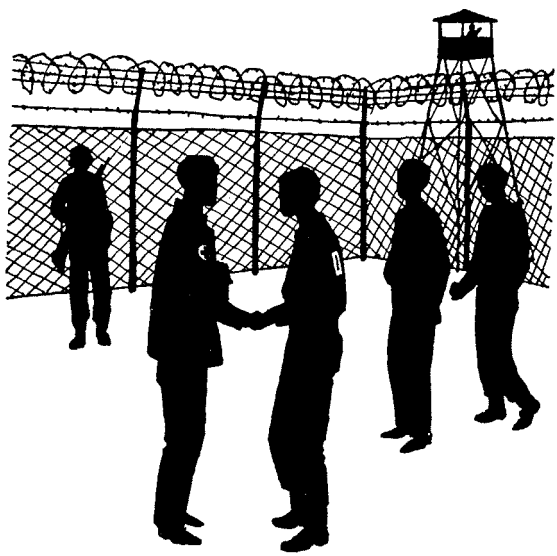
The International Festival of Red Cross and Health Films on Medical and Health Subjects, organized every two years by the Bulgarian Red Cross in close co-operation with the League of Red Cross Societies, was held in Varna, Bulgaria, from 21 to 30 June 1971. Thirty-five countries entered 201 films divided into four categories:

a) short and medium-length films on Red Cross and health subjects,
b) full-length feature films,
c) TV films on health subjects,
d) scientific and educational films on medical subjects.

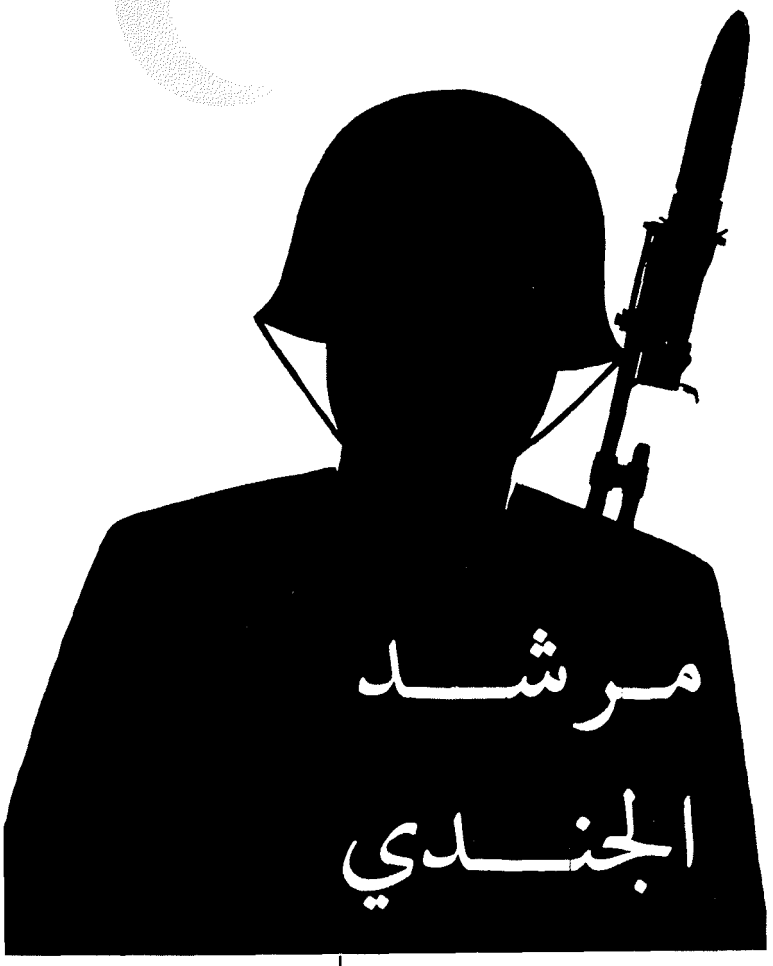
Thirty-one prizes were shared as follows: three to Bulgaria, Democratic Republic of Germany, Czechoslovakia and the USSR; two to USA/Mexico (co-production), France, Great Britain, and Switzerland; one to the Federal Republic of Germany, Belgium, USA, Hungary, Iran, Italy, Kenya, Netherlands, Vietnam (Democratic Republic) and Yugoslavia. A prize was also awarded to the International Committee of the Red Cross.

A page from the *Soldier's Manual* published by the ICRC.

DELEGATES OF THE ICRC



This man is a Delegate of the International Committee of the Red Cross. He wears a red cross with the words 'Comité International Genève'.
The Delegates of the ICRC side with neither party. They are entitled to visit prisoners of war, talk with them in private and provide them with relief and medicaments.



Cover and interior
of the cover
of the Arabic version
of the *Soldier's Manu*

لاتنسى أيها الجندى!

أن تقوم بحماية العدو والجريح والمريض والأسير المنزوع السلاح بنفس الطريقة التي ترغب أنت أن تقدم لك مثل هذه الحماية.

وتذكر أنك معرض يوماً من الأيام أن تقع جريحاً أو مريضاً أو أسيراً أو منزوع السلاح.

The ICRC presented its latest production, a short-length film made by one of its delegates, Mr. André Rochat, in the People's Democratic Republic of Yemen, and entitled *The Flag and the Men*. The work of the ICRC delegation in that country at the time when it became independent is related in the film, which shows, among other scenes, a visit carried out by ICRC delegates to the Mansoura Prison, and also how the surgical teams, operating under the auspices of the ICRC, exerted themselves in Aden and Mukalla. This film was awarded the second prize (Silver Medal) in Category A (short- and medium-length films on Red Cross and health subjects).

In the short and medium-length documentary category, the prize of the President of the Bulgarian Red Cross for the best film went to the Federal Republic of Germany for *Unknown Continent*, while the League of Red Cross Societies prize for the best Red Cross film went to *Kirathimo*, produced for the Kenya Red Cross.

Among the full-length fiction films, the top prize awarded by the Bulgarian Committee for Art and Culture went to *The Raging Moon* by the British producer Bryan Forbes, starring Malcolm MacDowel. The special League prize for the best film with a humanitarian subject went to Glen Ford for his incarnation of Dr. Rouben in *The Rage* (USA-Mexico).

The top prize for television films on health went to Czechoslovakia for *Attacks without Superstition*. A Bulgarian film, *Chemiotherapy of Malignant Tumours* won the Bulgarian Ministry of Public Health Prize for the best educational and scientific film. Gold medals went to the USSR for *Heart to Heart* and *Men Must Not Weep*; to Bulgaria for *Do You Know?* and *Biologic Potentials*; to Switzerland for *We, The Grave Diggers* and *Not Only at Christmas*; to the German Democratic Republic for *Dr Zomer II* and *Menu for the Future*.

During the Festival, the participants, most of whom came from western and eastern European countries, met in a very cordial atmosphere and established fruitful relations together.

Discussion meetings enabled participants to study various problems arising in Red Cross films; they fully supported the idea, in the making of such films, that there should be increasing co-operation between the organs of the Red Cross and the specialised bodies belonging to the world of cinema and television. In addition,

the Festival has become an important rendez-vous for producers and specialists in health education.

RED CROSS AND THE ENVIRONMENT

Pollution is one of the problems most widely discussed today. The Red Cross too is concerned about it. Can National Societies play an effective part in the campaign for a world-wide programme of action? The League review Panorama *(1971, No. 3) examines this topical question in a leading article, of which the following is an extract.*

... In many people's minds, such progress is praiseworthy but has very little to do with Red Cross. This is to overlook the responsibility of Red Cross as a member of the community—local or international. We can act as a pressure group on the most basic issue of environment: pollution. We are certainly interested in obtaining clean and pleasant surroundings for every family and fresh air and open spaces for young people to grow up in.

Even closer to Red Cross priorities and programmes is the whole area of efforts aimed at improving the quality of life—which could be described as the human environment. In its widest sense this includes improving community relations, reducing tensions and aggressions, promoting friendship between nations, races and social groups within a country. All these are easily recognisable as longstanding aims of Red Cross.

In terms of practical programmes, the fight for a better human environment is reflected over and again in Red Cross social development activities. Our efforts to make life more acceptable in the gigantic suburbs or the slums, to improve housing conditions, to provide space and opportunity for leisure activities, to ensure a normal existence for the old or handicapped, to facilitate human contacts and help people to live happier lives, in the big cities or the backstream of the countryside—all these are activities concerned with the human environment.

We must recognise that Red Cross is involved in environment. It is up to us to harness the interest being generated to the benefit of our activities in this field and to realize that we have a meaningful contribution to make here...

France

We have read in the French Red Cross Review [1] *the following interesting article on " The Red Cross and Present-Day Medico-Social Problems ".*

The French Red Cross Society's medico-social vocation is defined in article 1 of the Society's statutes: " The French Red Cross shall work for the prevention and alleviation of all human suffering. It shall participate in all medical preventive efforts, carrying its continuous action beyond disasters, particularly for the benefit of mothers and children ".

This does not mean that the onus of satisfying all needs or even certain needs is on the Society. But it is a service auxiliary to the public authorities and, as such, it must play a part in all efforts in the medico-social field. Its very simple organization enables it to adapt to circumstances. It is for that reason that, for several years in particular, it has unceasingly developed the range of its activities, modernizing and transforming its institutions. This is too little known. The efforts of the French Red Cross to keep abreast of changes in medical technology and to study new fields of action where it might extend its scope must be underlined.

French medical statistics show three main points:

— the decline of tuberculosis;

— longer life of children affected by congenital ailments, infirmities and affections which were formally fatal.

— increase of the elderly population.

These three points have guided the French Red Cross medico-social policy-making.

[1] *Vie et Bonté*, Paris, May 1971.

Pediatry

The regression of tuberculosis has resulted in the conversion of antituberculosis establishments.

Haemophilia. — On the other hand, children affected by new and by rare diseases are of grave concern to the French Red Cross. There are in France about 2000 cases of haemophilia, 600 of them of school age and for whom the French Red Cross has opened three establishments to provide them with medical care and schooling. For miopathy cases the French Red Cross has opened the first specialized centre at Hendaye and is planning a second at Meaux.

Metabolism deficiency. — Children afflicted with metabolic trouble require constant medical supervision and in some cases hospitalization. The French Red Cross has therefore made available to Parisian hospitals an institution which provides not only assurance of medical care but also an attractive setting more in keeping with real life.

The physically disabled. — According to an estimate by the *Direction Générale de la Population,* 1% of the juvenile population are physically handicapped. This proportion is unlikely to be reduced by road accidents. There are two establishments for these cases.

The question arises whether children with scoliosis are to be counted among the physically disabled. Whether they are or not, this affliction among girls is a new important problem. That the Montchic and La Rochelle institutions are proceeding along the right lines is proved by the success which they have achieved.

The mentally maladjusted. — Specialized establishments being important for these cases the French Red Cross could not remain aloof from this problem. It at present has sixteen establishments providing in-patient and out-patient care for 800 mentally maladjusted.

Hospitals — Retirement homes. — The French Red Cross still carries on its traditional work, managing nurseries, kindergartens, holiday camps and nursing homes for children.

Aged Persons

The French Red Cross of course takes a special interest in anything affecting children, but it does not as a consequence neglict adults. Its sanatoria are also being converted into functional re-education centres, since the need for them is keenly felt.

It is endeavouring to modernize its hospitals to meet the demands of the present day. But the main problem is that of the elderly of whom there are 8,500,000. Many have only a small pension from the welfare service as their sole resource. The French Red Cross can and does do a great deal for them. It already has five homes for the able-bodied elderly and three more are on the drawing-board. For the semi-invalid elderly there is a pilot centre at Eaubonne. In addition, at Satrouville the " Foyer Logement " offers them the possibility of a desirable independence in a community. Other schemes have also been tried, notably the system of home helps who enable the elderly to remain in their own homes whilst feeling that they are assisted and not alone.

Home helps. — In fact it is in this direction, in individual assistance, that part of the French Red Cross activity is oriented. Whilst it is important for an elderly person to be able to remain at home, it is equally so for sick people in rural areas. For many the French Red Cross home help service in rural areas has avoided or shortened hospitalization which might have been emotionally detrimental. That service, moreover, was set up as an experiment at the request of the Ministry. Its success has demonstrated it to be well worth while. It confirmed that the French Red Cross mission is indeed, in a manner of speaking, the testing ground for new forms of assistance.

Departing from routine and from the past, the French Red Cross must remain five to ten years in advance It must seek new solutions to problems which arise It must lead the way and then retire graciously from the scene That is its vocation.

MISCELLANEOUS

ASSISTANCE IN NATURAL DISASTER AND OTHER EMERGENCY SITUATIONS

The United Nations Economic and Social Council (ECOSOC), at its fifty-first session (Geneva, 5–30 July 1971), examined the question of " Assistance in Natural Disaster and Other Emergency Situations ". By 24 votes in favour, none against, and 2 abstentions, it adopted the resolution which we quote below.[1] ECOSOC's decision is yet to be approved by the twenty-sixth session of the General Assembly. Contingent upon that approval, the Secretary-General will be invited to appoint a Co-ordinator of relief in disaster situations and to set up a permanent relief bureau to co-ordinate assistance by the United Nations and specialized institutions.

Representatives of the ICRC and of the League have, of course, closely followed ECOSOC's work in this field.

The Economic and Social Council

Bearing in mind *that throughout history natural disasters and emergency situations have inflicted heavy loss of life and property, touching every people and every country,*

Being aware *of the varying needs of nations experiencing such disorders which present new challenges for international co-operation,*

Concerned *over the ability of the international community to come to the aid of the countries in a disaster situation,*

Recalling *General Assembly resolutions 2435 (XXIII) and 2717 (XXV), " Assistance in Cases of Natural Disaster ",*

Expressing *appreciation for the Secretary-General's comprehensive report (E/4994), and for its perceptive examination of all aspects of the question and taking note of the relevant passage in his statement to the Council of 5 July 1971,*

Noting *the study annexed to the Secretary-General's report on the legal status of disaster units operating under the aegis of the United Nations,*

[1] Res. 1612 (LI).

Mindful *of recent steps taken to improve evolving procedures in the United Nations system, voluntary agencies and individual Governments in the field of international disaster assistance,*

Bearing in mind *that assistance to meet the requests of the stricken countries without prejudice to their individual country programmes under the UNDP can be an effective contribution to the rehabilitation and development of the stricken areas,*

Bearing in mind *also that the possible response of the IBRD and other credit organizations and development agencies to a request from the Governments concerned for complementary assistance for the stricken areas, without prejudice to the assistance provided by these organizations for the normal development programmes of the stricken countries, can be an important element in the reconstruction and development of the stricken areas,*

Noting *the competence of the United Nations and its agencies, UNICEF, the World Food Programme, and the United Nations High Commissioner for Refugees, to render assistance in disasters and other emergency situations,*

Noting further *the key role which the UNDP Resident Representatives should play at the country level,*

Recognizing *the vital roles in international relief of the International Red Cross and other voluntary societies,*

Recognizing further *the necessity to ensure prompt, effective and efficient response to a Government's need for assistance at the time of a natural disaster or other emergency situation that brings to bear the resources of the United Nations, prospective donor countries, and voluntary agencies,*

1. Calls on the Secretary-General *to appoint a Disaster Relief Co-ordinator who would report directly to him, and who would be authorized, on behalf of the Secretary-General, to:*

(a) *Mobilize, direct and co-ordinate the relief activities of the various organizations of the United Nations system in response to a request for disaster assistance from a stricken State;*

(b) *Receive on behalf of the Secretary-General contributions offered to him for disaster relief assistance for particular emergency situations to be carried out by the United Nations, its agencies and programmes;*

(c) *Co-ordinate United Nations assistance with assistance given by intergovernmental and non-governmental organizations;*

(d) *Assist the Government of the stricken country to assess relief and other needs and to evaluate the priority of these needs, to disseminate this information to prospective donors and others concerned and to serve as a clearing house for assistance extended or planned by all sources of external aid;*

(e) *Promote the study, prevention, control and prediction of natural disasters including the collection and dissemination of information concerning technological developments;*

(f) *Assist in providing advice to Governments on pre-disaster planning in association with relevant voluntary organizations, particularly with the League of Red Cross Societies, and draw upon United Nations resources available for such purposes;*

(g) *Acquire and disseminate information relevant to planning and co-ordinating relief for disasters including the improvement and establishment of stockpiles in disaster prone areas and prepare suggestions to ensure the most effective use of available resources;*

(h) *Phase out relief operations under his aegis as the stricken country moves into the stage of rehabilitation and reconstruction but continue to interest himself, within the framework of his responsibilities for relief, in the activities of the UN agencies concerned with rehabilitation and reconstruction;*

(i) *Prepare an annual report for the Secretary-General to be submitted to the Economic and Social Council and the General Assembly;*

2. Recommends *that the Disaster Relief Co-ordinator be appointed by the Secretary-General normally for a term of five years;*

3. Endorses *the Secretary-General's proposals for a small permanent office in the United Nations which shall be the focal point in the United Nations system for disaster relief matters;*

4. Recommends *that this office be headed by the Disaster Relief Co-ordinator, be a distinct element within the United Nations Secretariat, and be augmented as necessary by short-term secondment of personnel for individual emergencies;*

5. Requests the *Secretary-General to prepare a study for its 53rd session taking into account any relevant suggestions and the experience gained by the Disaster Relief Co-ordinator, on ways and means to enable the Disaster Relief Co-ordinator adequately to perform the functions entrusted to him under this resolution;*

6. Further endorses *the plan for a roster of volunteers to be drawn from experienced staff members of the United Nations system and interested non-governmental organizations who could be made available at very short notice;*

7. Recommends *that the Disaster Relief Co-ordinator should maintain contact with the Governments of States members of the United Nations and of the specialized agencies and the IAEA concerning available aid in emergency situations such as food supplies, medicines, personnel, transportation, communications, as well as advice to countries in pre-disaster planning and preparedness;*

8. Invites *potential recipient governments,*

(a) *to establish disaster contingency plans with appropriate assistance from the Disaster Relief Co-ordinator,*

(b) *to appoint a single National Disaster Relief Co-ordinator to facilitate the receipt of international aid in times of an emergency;*

(c) *to establish stockpiles of emergency supplies such as tents, blankets, medicine and non-perishable foodstuffs;*

(d) *to consider appropriate legislative or other measures to facilitate the receipt of aid, including overflight and landing rights and necessary privileges and immunities for relief units;*

(e) *to improve national disaster warning systems;*

9. Invites *potential donor governments:*

(a) *to respond promptly to any call by the Secretary-General or by the Disaster Relief Co-ordinator on his behalf;*

(b) *to consider and to continue offering on a wider basis emergency assistance in disaster situations;*

(c) *to inform the Disaster Relief Co-ordinator in advance about the facilities and services they might be in a position to provide immediately including where possible relief units, logistical support and means of effective communications;*

10. Further invites *all organizations of the United Nations system and all other organizations involved to co-operate with the Disaster Relief Co-ordinator ;*

11. Recommends *that the General Assembly at its twenty-sixth session endorse the foregoing proposals and recommendations.*

The Neutrality of a XVII Century Field Hospital

Général-major médecin E. Evrard, whose article on aero-medical evacuation in war-time was published recently in the International Review *has now written a well documented study on the neutrality of a field hospital in the XVIIth century.*[1] *As, according to him, this was the first time a field hospital was granted neutral status, we believe our readers will be interested in the facts and author's comments contained in the following extract:*

In her fascinating study, published in 1959, entitled " Le service sanitaire de l'armée espagnole des Pays-Bas à la fin du XVI[e] et au XVII[e] siècle ", Miss Lucienne van Meerbeeck, conservator of the General Archives of the Kingdom of Belgium, relates the following episode:

" In 1677, a French military hospital abandoned in the middle of the war in one of our provinces was placed under the safeguard of the Netherlands' Governor General and guaranteed protection jointly by the coats of arms of the kings of France and Spain."

Miss Meerbeck referred to the letter written on August 23, 1677, in the Thieu Camp, in the name of Charles II of Spain, by the Governor General of the Netherlands, the Duke of Villa-Hermosa, promising protection to the French military hospital at Marchienne-au-Pont, in the Hainaut region. The original draft of this letter is

[1] Special issue of *Revue internationale des services de santé des armées de terre, de mer et de l'air,* Paris 1967.

in the General Archives of the Kingdom in Brussels. The text, which we quote below, was kindly communicated to us by Miss van Meerbeeck.

So far as we know, this letter, which is undeniably legal in character, is the first document ever to effectively confer genuine neutral status on a field medical unit after its capture.

Viewed from the standpoint of the times and from that, particularly, of the period two centuries later when ideas were leading to the birth of the great humanitarian conventions, the event is of no little importance . . .

. . . This grant of safeguard to the hospital on August 23, 1677, was concomitant with the operations conducted first by the army of William of Orange and then by that of the Duke of Villa-Hermosa which laid siege to Charleroi during the first fortnight of August. The Marchienne hospital, with its staff and patients, was captured on August 6 by the Spanish forces. After the raising of the siege of Charleroi, the Spanish and Dutch troops continued to occupy the region, maintained their hold over the Lowlands, laid siege to Binche and retook it from the French. Care for the patients, the hospital supplies, maintenance and administration, in a word, the operation of the captured hospital, could only continue provided the commander of the Spanish forces agreed to direct logistic support being given by the French forces at Charleroi to their captive compatriots, without any measures being taken to harass the beneficiaries. The arrangement was made with due regard for juridical formalities. Such were the circumstances of a military order surrounding this deed of safeguard...

The text of the deed is as follows:

Acte de Sauvegarde pour l'Hôpital de France estably à Marchienne-au-Pont.

Don Carlos de Gurria, Aragon y Borja, Duc de Villa-Hermosa, Comte de Luna, Gouverneur Général des Pays-Bas.

A tous les lieutenants gouverneurs, etc.

Comme nous avons prins et nous prennons et mettons en la protection et sauvegarde espéciale de Sa Majesté et la Nôtre, les Directeurs,

Controlleurs, médecins, chirurgiens et autres officiers de l'hôpital de l'Armée du Roy Très chrétien estably à Marchienne au Pont et les soldats malades y estants jusques au jour qu'ils seront guéris et sortiront du dit hospital, ensemble tous les serviteurs, biens, meubles et tous aultres choses qui oncques y estants; nous vous mandons et commandons au nom de Sa dite Majesté bien expressément de ne faire ny souffrir estre faictes au dict hospital, Directeur, Controlleurs, médecins, chirurgiens, aultres officiers, soldats malades, jusques au jour qu'ils seront guéris et sortiront du dict hospital, serviteurs, biens, meubles et aultres choses susdites, aucune fautes, dommages, torts, forces, pilleries, mangeries, exactions ou oppressions en aulcune manière à peine d'encourrir l'indignation de Sa Majesté et la Nôtre et d'estre puni comme infracteurs de nos sauvegardes et commandements. Et afin que de ce que dessus, personne ne puisse prétendre cause d'ignorance, nous avons consenty et consentons que l'on puisse et pourra mettre et afficher les blasons des armes de Sa Majesté et les nôtres en tels endroits du dict hospital qui sera trouvé convenir. Si voulons et mandons que la copie authentique de ceste notre présente sauvegarde collationnée par le Sieur Lambert, Directeur du dict hospital, servira aux officiers susdits pour pouvoir aller et venir du dict Marchienne-au-Pont à Charleroi. A durer la présente sauvegarde pendant qu'il y aura des malades dans le dict hospital.

Fait au camp de Thieu, le 23 d'Août 1677.

As can be seen, this deed, already at that time, contained the gist of article 19 and the first paragraph of article 33 of the First Geneva Convention of August 12, 1949. Article 19 defines the protection of fixed establishments and mobile medical units of the medical service. Like the deed of safeguard, its first paragraph provides that " fixed establishments and mobile medical units . . . shall at all times be respected and protected by the Parties to the conflict. Should they fall into the hands of the adverse Party, their personnel shall be free to pursue their duties as long as the capturing Power has not itself ensured the necessary care of the wounded and sick found in such establishments and units."

As stated in the Commentary on the Convention, there is a period after the capture during which a medical unit will remain a whole, during which its elements cannot be separated but must be treated alike. This is a period in which the wounded and sick within the unit or its neighbourhood need that unit's help. Apart from the fact that the authorities controlling it are not the same,

the establishment will continue to function as if it had not been captured. This phase must continue until such time as the Capturing Power is itself in a position to provide the wounded with all the necessary care.

The deed of safeguard, concise as it was, afforded the same guarantees to the hospital at Marchienne-au-Pont, even at that time.

Protection of the material of mobile medical units of the Armed Forces is provided for in the first paragraph of article 33 of the First 1949 Convention. It states that " the material of these mobile medical units which falls into the hands of the enemy shall be reserved for the care of wounded and sick."

The third paragraph of the same article lays down that the material and stores defined therein shall not be intentionally destroyed.

The broad outline of these provisions is contained in the deed of safeguard.

It is true that this deed made no provision for what was to be done with the wounded after their recovery nor the hospital staff and equipment when the hospital was closed. It is no less creditable for this however, and it would be unfair to regard it otherwise than as a considerable step forward or to criticize it for not guaranteeing more than the normal operation of the captured hospital.

A third important point in the deed of safeguard is the guarantee afforded by the coats of arms displayed on the captured military hospital: this contained the germ of an idea which much later led to the use of a protective emblem recognized by belligerents, to indicate the neutral status of medical establishments and their personnel.

. . . . . .

At the conclusion of this study, it must be admitted that, for want of documents, the granting of safeguard to the Marchienne field hospital has not been fully explained.

Our first hypothesis of personal intervention by the Duke of Villa-Hermosa was plausible because he possessed a personality which had specific traits characteristic of a man who, spontane-

ously or under his wife's urging, would act with this degree of charity and magnanimity. In addition, the Comte de Bergeyck might well have included the deed of safeguard among those " weaknesses " and " excessive good nature " which he deprecated in his master. If the event is seen from this angle as an initiative taken by the Duke, we must logically conclude that it had a certain importance in his eyes and therefore deserved to be mentioned either by himself or someone else at his instigation. However, in fact, it would seem that the Duke did not take the trouble of bringing it to the fore: there is no mention of it in his memoirs. Evidence of similar acts during his last two years in office as Governor General of the Netherlands may be sought in vain, in spite of the abundance of military action at that time, or during his vice-regency in Catalonia.

As we have already said, therefore, it would appear from information at present available that the granting of safeguard to the Marchienne hospital was a single, exceptional, and even accidental, incident. This aspect itself suggests another hypothesis which we have considered earlier, namely that the act was initiated and the deed drawn up by one of the Duke's entourage. In this connection, we have mentioned the extremely important role which Counsellor Vaes might have played, in view of the negotiations he conducted at Marchienne and Deinze in 1676 and 1677. He was in the right place to receive petitions from persons concerned about the hospital and to undertake the drawing up of the deed of safeguard and submit it to the Governor General for signature. Others in direct contact with the Duke, such as his legal adviser, the Court Martial Prosecutor, and his spiritual counsellor, the Vicar-General, or even the administrator-general of the Spanish field hospital, being in close contact with him in the field, could have contributed to the drafting of the deed. They could have submitted it to the Governor General's approval and signature, with the reams and reams of other administrative paper-work, without necessarily being aware of the exceptional and novel character of the document.

This step, of which the place in the evolution of humanitarian doctrine can only be assessed with the hind-sight which only the passage of time confers, was apparently taken so haphazardly—as

if it were mere routine in normal administrative procedure, no more than local in scope—that it received no attention from historians of the law of war and was not mentioned in the official records of the belligerents involved.

The deed of safeguard granted to the French military hospital at Marchienne-au-Pont on August 23, 1677, thus appears to be a local measure, tentative and frail like any beginning. And yet, in substance and form, it must be considered a forerunner of the humanitarian Conventions, or a seed sown by the hand of fate which brought about the meeting of certain men to husband it in the midst of war.

The Duke of Villa-Hermosa's action fell into oblivion like so many others in a long tradition of charity. Gürlt in his study which was published in the years immediately following the 1864 Geneva Convention, showed how rich and profuse were such acts. But Villa-Hermosa's escaped his attention.

Yet this deed of 1677 is one of the most significant. As such, it deserves to be brought out of its seclusion to take its place with all the ancient documents in which the " humanity " of our ancestors is expressed.

THE BASIC HOSPITAL'S FUNCTION

The concept of what a hospital should be has continuously evolved over the centuries. Today the hospital must be adapted to changes in health programmes which themselves depend on the population's medical requirements. In a recent article [1] *of which we give quotations below, Dr. R. F. Bridgman shows that the* basic hospital, *whose functions he defines, has replaced the rural hospital, and he gives also his view of future developments.*

We can now see the results of the " dispensary " concept which has been applied on a large scale in the USSR. Simple, inexpensive methods have been used successfully to restrain the growth of

[1] See *World Health*, the World Health Organization magazine, Geneva, December 1970.

many of the commonplace, slowly-evolving ailments. Now that the incidence of contagious disease has been cut back, this seems to be the direction public health will take in the years ahead.

Either of their own accord or encouraged by the health authorities, the public are going to demand ever-increasing basic medical care. For one thing, their needs are growing with increased life expectancy, which brings with it greater prevalence of the chronic degenerative diseases; for another, the rapid and extremely serious drop in the proportion of general practitioners, in contrast with the multiplication of specialists, leaves a bewildered and unsatisfied mass of sufferers who happen to be afflicted by everyday complaints. Finally, the education of the public is improving daily, thanks to the power of the information media. At one time, the symptoms which accompanied the ailments of old age used to be accepted with resignation; today this has given way to a demand for treatment. No one any longer accepts avoidable suffering.

It follows that the call for institutions to meet basic medical needs will soon make itself heard in no uncertain fashion. What are these needs?

They might be divided into three categories.

The first is for the recognition of pathological conditions at an early stage. Such conditions include, for example, arterial hypertension, rheumatism, tuberculosis, glaucoma, cancer of the uterus, of the tongue, of the breast and of the skin, diabetes, chronic bronchitis, congenital malformations, irregularities in the gestation and growth of the child, psycho-neurotic disorders, disorders of the sensory organs, venereal diseases and occupational illness—in other words common ailments which can generally be more or less easily diagnosed and so receive attention in good time.

The second category covers basic medical care in the traditional field of curative medicine and general surgery. It includes cardiovascular and cerebral ailments, chronic nephritis, diseases of the lungs, intestinal ulcers, appendicitis, hernia, prolapsus of the uterus, fibroma and so forth. To these should be added the usual facilities for obstetrics, gynaecology and pediatrics.

Our third category of basic medical needs covers the rehabilitation of the victims of accidents or diseases who suffer from permanent injuries usually affecting the locomotor apparatus.

In all three groups, treatment may be on an out-patient basis or may require periods of hospitalization.

The institution where these services can be made available to the public is the *basic hospital*, manned by general practitioners and surgeons, midwives, pediatricians, nurses and rehabilitation technicians. It is essentially an establishment equipped to treat the everyday ailments which occur in a community enjoying the protection of the usual range of preventive medical services; unusual cases should be referred to the specialist departments of big hospitals . . .

. . . Under no circumstance should the basic hospital be regarded as existing in a vacuum. It must be part of a public health network organized on regional lines. In other words, it must constitute the central reference point for basic health institutions situated in the villages and suburbs, each of which would serve about 20,000 persons. Further, there should be a two-way flow of patients between the basic hospital and the regional hospital centre, one made up of persons whose condition calls for specialized hospital treatment and, in the other direction, convalescents who would benefit from rehabilitation facilities in their own communities.

Conceived in this way, the basic hospital becomes the key element in a comprehensive health programme. It has the great virtue of operating both economically and efficiently, while at the same time offering attractive working conditions to doctors, nurses and other medical and social personnel . . .

. . . So far, we have considered the basic hospital in terms of its role as an essentially practical and direct instrument for the execution of an integrated health programme. To complete the picture we must look also at the administrative framework in which it will function. *The basic hospital of the type we are considering is something entirely different from the traditional general hospital.* The inclusion of dispensaries providing preventive, curative and rehabilitation services, the participation of all branches of the medical profession, its integration in a regional health system, are all features which give it a new character, and this implies the creation of equally new administrative machinery . . .

. . . Last, the architecture of the basic hospital will call for new thinking. Here, adaptability in the use of the building must have

high priority. One can easily imagine that an energetic basic health policy might lead to increased employment of the dispensaries for out-patient treatment, with a relative reduction in the numbers of hospital cases. It will be necessary therefore to continually readapt the physical premises. Only standardized buildings designed on the unit construction principle can be expected to provide a flexible enough structure to allow for the changing demands which the general public will make. . .

BOOKS AND REVIEWS

CESAR GOMEZ GUILLERMOPRIETO: "OBJETO Y FUNCIONAMIENTO DE LA CRUZ ROJA INTERNACIONAL" [1]

The author of this study first relates Henry Dunant's reaction at Solferino and depicts what the Geneva Conventions represent for mankind; he then situates more closely the place of the Red Cross today among the other international institutions. In a third chapter, he examines the significance of the Geneva Conventions of 1949, but without stating that they are the outcome of earlier humanitarian conventions signed between 1864 and 1929.

The title of the study: "Purpose, Organization and Working of the International Red Cross", is warranted by the contents of the next few chapters. The author points out, in particular, the role of neutral intermediary assumed, in all circumstances, by the Red Cross, and defines also the mission of National Societies and of their federation, the League, particularly when natural disasters occur, and when a more extensive application of development programmes is required.

Some space is devoted to ICRC activities during the Second World War. The author calls to mind, here, the role of the Prisoners of War Central Agency, and the vast action carried out by the International Committee to ensure the distribution of relief supplies to prisoners of war throughout the whole world. In 1945, families dispersed at the end of the war were reunited, while conflicts breaking out in various regions of the earth have obliged the ICRC to continue its humanitarian action.

The last chapter is devoted to the Mexican Red Cross and gives readers the opportunity to find out, in clear and useful fashion, more of the development and internal structure of that National Society and of all the various activities which it performs in peacetime, especially in the medical field. There is an extensive bibliography at the end.

P.J.

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[1] Universidad Nacional Autónoma de México, 1971, 124 pp.

" POUR UNE POLITIQUE DE LA SANTÉ " [1]

This yearbook contains contributions from various Swiss doctors, nurses, public health administrators and hospital directors on the achievements and objectives of a Swiss policy for health. The articles are noteworthy for the competence of the authors and for the ideas they defend. We quote below from one of general interest, by Dr. Pierre Rentchnick, which analyses " the evolution of medical thinking " and concludes as follows: [2]

...It must be admitted that the University has lost the monopoly in medical training and information. It must divide its teachings in terms of the student's future, that is to say for the practitioners, the theorists and the research workers. The same old medicine and the same old diplomas are valid no longer. Universities must launch out into pedagogic research, they must study modern management methods, and they must transfer some of their privileges to regional hospitals—state and private enterprise—which have perhaps more realistic ideas of competition, management, efficiency, profitability and the value of time. Indifference to the value of time is a serious flaw in official medical and hospital organization. The growing interest in data processing will, it seems likely, enable the notion of time to be taught. If so, we shall realize that there are practitioners who have not donned the cap and gown who prove remarkable teachers of future colleagues.

The general practitioner, when better informed, better equipped, will no longer be doomed to perpetual isolation. Thanks to computer terminals he will be constantly informed and will participate in the compilation of a unique medical file linking him permanently to the hospital. The general practitioner's standing will be enhanced and this will contribute to the progressive elimination of the outmoded system of medical grading, for every doctor—be he general practitioner or specialist—has vital responsibilities. The general practitioner working with a group will thus have an important role to play in medicine of the future, and it may be expected that doctors will once again be attracted by a form of medicine that is more complete than that of the specialist.

[1] Published by the " Nouvelle Société helvétique ", Berne 1971, 280 pp.

[2] Our translation.

If doctors use imagination to set up new structures based on modern techniques of intellectual and material organization in their profession, if they can make their views prevail when efforts are made to draw up a general health policy, then they will be able to move from the archaic and craft era of medicine—imperfect in spite of its achievements since the last war—to the era of technology and effectiveness in medical science. As Professor Hamburger said two years ago, " the function of the doctor is not to produce medical data but to receive them in order to translate them into effective action; whether he acquires them from a computer or from any other source has no bearing on the nature and ethics of his mission ".

...Humanitarianism and technology in medicine are not mutually exclusive: they are complementary. To believe that the " bedside manner " is the main asset in medicine is totally archaic. Medicine is fortunately becoming highly technical, but the doctor must, by his personality, compassion and psychological gifts, humanize this scientific approach to the patient and his illness. In this respect, the evolution of modern medical thinking is not in contradiction with recognized traditions.

The Socio-Psychological Aspects of Rehabilitation, Studied by Researchers, *International Rehabilitation Review*, New York, 4th Quarter, 1970.

Comparative research on the social and socio-psychological aspects of disability and rehabilitation can make outstanding contributions to the development of a universally valid theory. It is equally of value to the testing of different types of social policies about the disabled or about the social status of physicians and other rehabilitation professionals that have a very significant effect upon the rehabilitation process and the outcome of rehabilitation of different types of disabled people.

An example of such an extremely useful comparative research is the one undertaken by the European Coal and Steel Community (European Communities Commission) in Belgium, Holland, France and West Germany. In this study recent legislation passed in these countries in order to facilitate the employment and re-employment of handicapped workers was studied and evaluated in order to determine the most helpful types of policies for the employment of the handicapped. Comparative evaluation of different types of social policies enacted in countries with varying or similar socio-cultural conditions would be extremely useful to social policy-makers since it could provide them with concrete and tested information about the nature of the policies that

must exist if the employment and promotion chances of the handicapped in a wide range of occupations are to be maximized.

The development of cross-cultural research as a collaborative effort of investigators in a number of different countries pre-supposes an effective clearinghouse of research information not only concerning " who is doing what and in which country " but also concerning " who is interested in or planning to do what research in which country ". Such comparative research would enable investigators to compare their findings and to eventually reach conclusions that would be valid for a variety of socio-cultural environments.

Only in this way will it be possible to build theories explaining the behaviour of the disabled, the rehabilitation process, the after-rehabilitation adjustment processes, the rehabilitation professionals-rehabilitant types of interactions, the types of interaction taking place among the different rehabilitation professionals and related behaviour under different socio-cultural models.

The Needs: More Health Care, *Gazette,* Pan American Health Organization, Washington, 1970, No. 4.

...An important reason for the growing sense of urgency that medical planning has acquired throughout Latin America and the Caribbean is the increasing recognition of the close links between health and economic development....

...Although statistics compiled during the last four years show progress is being made in improving health care, they also make it clear that a lot still needs to be done to meet present and future demands.

Of major concern are many of the 120 million people who live in rural areas. " This is perhaps the basic problem in Latin America," says Dr. Horwitz. " It is a problem of giant proportions and one against which progress is slow."

For instance, at least 30 million rural inhabitants have little or no access to even minimum health services, with about 10 million lacking water and many more sewage facilities. As a result, mortality rates are three and a half times higher than those of urban areas.

Another serious shortage involves doctors, the overall ratio in Middle and South America being about six physicians for every 10,000 people at a time when health authorities believe that at least 10 are needed. Shortages in the rural areas of some individual countries are even more acute.

Nurses are also in short supply. The ratio of graduate nurses in Middle America is a little less than four per 10,000 people compared to almost 34 in North America. South America's ratio is not quite three....

EXTRACT FROM THE STATUTES OF THE INTERNATIONAL COMMITTEE OF THE RED CROSS

(AGREED AND AMENDED ON SEPTEMBER 25, 1952)

ART. 1. — The International Committee of the Red Cross (ICRC) founded in Geneva in 1863 and formally recognized in the Geneva Conventions and by International Conferences of the Red Cross, shall be an independent organization having its own Statutes.

It shall be a constituent part of the International Red Cross.[1]

ART. 2. — As an association governed by Articles 60 and following of the Swiss Civil Code, the ICRC shall have legal personality.

ART. 3. — The headquarters of the ICRC shall be in Geneva.

Its emblem shall be a red cross on a white ground. Its motto shall be " Inter arma caritas ".

ART. 4. — The special role of the ICRC shall be:

(a) to maintain the fundamental and permanent principles of the Red Cross, namely: impartiality, action independent of any racial, political, religious or economic considerations, the universality of the Red Cross and the equality of the National Red Cross Societies;

(b) to recognize any newly established or reconstituted National Red Cross Society which fulfils the conditions for recognition in force, and to notify other National Societies of such recognition;

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[1] The International Red Cross comprises the National Red Cross Societies, the International Committee of the Red Cross and the League of Red Cross Societies. The term " National Red Cross Societies " includes the Red Crescent Societies and the Red Lion and Sun Society.

(c) to undertake the tasks incumbent on it under the Geneva Conventions, to work for the faithful application of these Conventions and to take cognizance of any complaints regarding alleged breaches of the humanitarian Conventions;

(d) to take action in its capacity as a neutral institution, especially in case of war, civil war or internal strife; to endeavour to ensure at all times that the military and civilian victims of such conflicts and of their direct results receive protection and assistance, and to serve, in humanitarian matters, as an intermediary between the parties;

(e) to contribute, in view of such conflicts, to the preparation and development of medical personnel and medical equipment, in co-operation with the Red Cross organizations, the medical services of the armed forces, and other competent authorities;

(f) to work for the continual improvement of humanitarian international law and for the better understanding and diffusion of the Geneva Conventions and to prepare for their possible extension;

(g) to accept the mandates entrusted to it by the International Conferences of the Red Cross.

The ICRC may also take any humanitarian initiative which comes within its role as a specifically neutral and independent institution and consider any questions requiring examination by such an institution.

ART. 6 (first paragraph). — The ICRC shall co-opt its members from among Swiss citizens. The number of members may not exceed twenty-five.

SOME PUBLICATIONS ON THE RED CROSS *

	Sw. Fr.
Jean Pictet	
— Red Cross Principles, 155 pp.	8.—
— The Principles of International Humanitarian Law, 61 pp.	8.—
— The Doctrine of the Red Cross, 19 pp.	2.—
— The Laws of War, 11 pp.	2.—
Henri Coursier	
— The International Red Cross, 131 pp.	3.50
Jean-Georges Lossier	
— Fellowship—The Moral Significance of the Red Cross, 106 pp.	4.—
— The Red Cross and Peace, 31 pp.	3.—
Bernard Gagnebin and Marc Gazay	
— Encounter with Henry Dunant. Geneva, Ed. Georg, 130 pp.	9.50

*

The Red Cross. Lausanne, Ed. Rencontre, 32 pp.	1.—

* Obtainable from the ICRC, 7 avenue de la Paix, CH-1211 Geneva 1.

THE GENEVA CONVENTIONS OF AUGUST 12, 1949[1]

Some publications

	Sw. fr.
The Geneva Conventions of August 12, 1949. 2nd Ed. 1950. 245 pp.	9.—
Commentary published under the general editorship of Mr. J. Pictet, member of ICRC:	
— **Vol. 1:** Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field — 466 pp. bound	18.—
paper-back	15.—
— **Vol. 2:** Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea — 320 pp. bound	23.—
paper-back	18.—
— **Vol. 3:** Geneva Convention relative to the Treatment of Prisoners of War — 764 pp. bound	38.—
paper-back	33.—
— **Vol. 4:** Geneva Convention relative to the Protection of Civilian Persons in Time of War — 660 pp. bound	33.—
paper-back	28.—
Brief Summary for Members of Armed Forces and the General Public, 13 pp.	1.50
Course of Five Lessons, 102 pp.	7.—
Essential Provisions, 4 pp.	0.30
Soldier's Manual, 24 pp.	0.50

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Transparencies:

Third series of drawings (1970) by Claude Falbriard, illustrating the application of the Geneva Conventions. Twenty colour slides, 24 × 36 mm. with comments	18.—

*

1) These publications and slides and the full list of ICRC publications may be obtained from the ICRC Press and Information Service, 7, avenue de la Paix, CH-1211 Geneva 1.

ADDRESSES OF NATIONAL SOCIETIES

AFGHANISTAN — Afghan Red Crescent, *Kabul.*

ALBANIA — Albanian Red Cross, 35, Rruga e Barrikadavet, *Tirana.*

ALGERIA — Central Committee of the Algerian Red Crescent Society, 15 bis, Boulevard Mohamed V, *Algiers.*

ARGENTINA — Argentine Red Cross, H. Yrigoyen 2068, *Buenos Aires.*

AUSTRALIA — Australian Red Cross, 122-128 Flinders Street, *Melbourne, C. 1.*

AUSTRIA — Austrian Red Cross, 3 Gusshausstrasse, Postfach 39, *Vienna IV.*

BELGIUM — Belgian Red Cross, 98, Chaussée de Vleurgat, *Brussels 5.*

BOLIVIA — Bolivian Red Cross, Avenida Simon Bolivar, 1515 (Casilla 741), *La Paz.*

BOTSWANA — Botswana Red Cross Society, P.O. Box 485, *Gaberones.*

BRAZIL — Brazilian Red Cross, Praça da Cruz Vermelha 12 zc/86, *Rio de Janeiro.*

BULGARIA — Bulgarian Red Cross, 1, Boul. S. S. Biruzov, *Sofia.*

BURMA — Burma Red Cross, 42, Strand Road, Red Cross Building, *Rangoon.*

BURUNDI — Red Cross Society of Burundi, rue du Marché 3, P.O. Box 324, *Bujumbura.*

CAMEROON — Central Committee of the Cameroon Red Cross Society, rue Henry-Dunant, P.O.B. 631, *Yaoundé.*

CANADA — Canadian Red Cross, 95 Wellesley Street, East, *Toronto 284* (Ontario).

CEYLON — Ceylon Red Cross, 106 Dharmapala Mawatha, *Colombo VII.*

CHILE — Chilean Red Cross, Avenida Santa Maria 0150, Correo 21, Casilla 246V., *Santiago de Chile.*

CHINA — Red Cross Society of China, 22 Kanmien Hutung, *Peking, E.*

COLOMBIA — Colombian Red Cross, Carrera 7a, 34-65, Apartado naciona l1110, *Bogota* D.E.

CONGO — Red Cross of the Congo, 41, Avenue Valcke P.O. Box 1712, *Kinshasa.*

COSTA RICA — Costa Rican Red Cross, Calle 5a, Apartado 1025, *San José.*

CUBA — Cuban Red Cross, Calle 23 201 esq. N. Vedado, *Havana.*

CZECHOSLOVAKIA — Czechoslovak Red Cross, Thunovska 18, *Prague I.*

DAHOMEY — Red Cross Society of Dahomey, P.O. Box 1, *Porto Novo.*

DENMARK — Danish Red Cross, Ny Vestergade 17, *Copenhagen K.*

DOMINICAN REPUBLIC — Dominican Red Cross, Calle Juan Enrique Dunant, Ensanche Miraflores, *Santo Domingo.*

ECUADOR — Ecuadorian Red Cross, Calle de la Cruz Roja y Avenida Colombia 118, *Quito.*

ETHIOPIA — Ethiopian Red Cross, Red Cross Road No. 1, P.O. Box 195, *Addis Ababa.*

FINLAND — Finnish Red Cross, Tehtaankatu 1 A, Box 14168, *Helsinki 14.*

FRANCE — French Red Cross, 17, rue Quentin Bauchart, *Paris* (8e).

GERMANY (Dem. Republic) — German Red Cross in the German Democratic Republic, Kaitzerstrasse 2, *Dresden A. 1.*

GERMANY (Federal Republic) — German Red Cross in the Federal Republic of Germany, Friedrich-Ebert-Allee 71, 5300, *Bonn 1,* Postfach (D.B.R.).

GHANA — Ghana Red Cross, P.O. Box 835, *Accra.*

GREAT BRITAIN — British Red Cross, 9 Grosvenor Crescent, *London,* S.W.1.

GREECE — Hellenic Red Cross, rue Lycavittou 1, *Athens 135.*

GUATEMALA — Guatemalan Red Cross, 3.ª Calle 8-40, Zona 1, *Guatemala C.A.*

GUYANA — Guyana Red Cross, P.O. Box 351, Eve Leary, *Georgetown.*

HAITI — Haiti Red Cross, Place des Nations Unies, B.P. 1337, *Port-au-Prince.*

HONDURAS — Honduran Red Cross, Calle Henry-Dunant 516, *Tegucigalpa.*

HUNGARY — Hungarian Red Cross, Arany Janos utca 31, *Budapest V.*

ICELAND — Icelandic Red Cross, Øldugøtu 4, Post Box 872, *Reykjavik.*

INDIA — Indian Red Cross, 1 Red Cross Road, *New Delhi 1.*

INDONESIA — Indonesian Red Cross, Djalan Abdulmuis 66, P.O. Box 2009, *Djakarta.*

IRAN — Iranian Red Lion and Sun Society, Avenue Ark, *Teheran.*

IRAQ — Iraqi Red Crescent, Al-Mansour, *Baghdad.*

IRELAND — Irish Red Cross 16 Merrion Square, *Dublin 2.*

ITALY — Italian Red Cross, 12 via Toscana, *Rome.*

IVORY COAST — Ivory Coast Red Cross Society, B.P. 1244, *Abidjan.*

JAMAICA — Jamaica Red Cross Society, 76 Arnold Road, *Kingston 5.*

JAPAN — Japanese Red Cross, 5 Shiba Park, Minato-Ku, *Tokyo 105.*

JORDAN — Jordan National Red Crescent Society, P.O. Box 10 001, *Amman.*

KENYA — Kenya Red Cross Society, St Johns Gate, P.O. Box 712, *Nairobi.*

KHMER REPUBLIC — Khmer Red Cross, 17, Vithei Croix-Rouge khmère, P.O.B. 94, *Phnom-Penh.*

KOREA (Democratic People's Republic) — Red Cross Society of the Democratic People's Republic of Korea, *Pyongyang.*

KOREA (Republic) — The Republic of Korea National Red Cross, 32-3 Ka Nam San-Donk, *Seoul.*

KUWAIT — Kuwait Red Crescent Society, P.O. Box 1359, *Kuwait.*

LAOS — Lao Red Cross, P.B. 650, *Vientiane.*

LEBANON — Lebanese Red Cross, rue Général Spears, *Beirut.*

ADDRESSES OF NATIONAL SOCIETIES

LIBERIA — Liberian National Red Cross, National Headquarters, 13th Street-Sinkor, P.O. Box 226, *Monrovia.*

LIBYAN ARAB REPUBLIC — Libyan Red Crescent, Berka Omar Mukhtar Street, P.O. Box 541, *Benghazi.*

LIECHTENSTEIN — Liechtenstein Red Cross, FL-9490 *Vaduz.*

LUXEMBOURG — Luxembourg Red Cross, Parc de la Ville, C.P. 234, *Luxembourg.*

MADAGASCAR — Red Cross Society of Madagascar, rue Clemenceau, P.O. Box 1168, *Tananarive.*

MALAWI — Malawi Red Cross, Hall Road, Box 247, *Blantyre.*

MALAYSIA — Malaysian Red Cross Society, 519 Jalan Belfield, *Kuala Lumpur.*

MALI — Mali Red Cross, B.P. 280, route de Koulikora, *Bamako.*

MEXICO — Mexican Red Cross, Avenida Ejército Nacional, nº 1032, *Mexico* 10, D.F.

MONACO — Red Cross of Monaco, 27, boul. de Suisse, *Monte-Carlo.*

MONGOLIA — Red Cross Society of the Mongolian People's Republic, Central Post Office, Post Box 537, *Ulan Bator.*

MOROCCO — Moroccan Red Crescent, rue Benzakour, B.P. 189, *Rabat.*

NEPAL — Nepal Red Cross Society, Tripureshwar, P.B. 217, *Kathmandu.*

NETHERLANDS — Netherlands Red Cross, 27 Prinsessegracht, *The Hague.*

NEW ZEALAND — New Zealand Red Cross, 61 Dixon Street, P.O.B. 6073, *Wellington C.2.*

NICARAGUA — Nicaraguan Red Cross, 12 Avenida Noroeste, 305, *Managua,* D.N.

NIGER — Red Cross Society of Niger, B.P. 386, *Niamey.*

NIGERIA — Nigerian Red Cross Society, Eko Akete Close, off St. Gregory Rd., Onikan, P.O. Box 764, *Lagos.*

NORWAY — Norwegian Red Cross, Parkveien 33b, *Oslo.*

PAKISTAN — Pakistan Red Cross, Dr Dawood Pota Road, *Karachi 4.*

PANAMA — Panamanian Red Cross, Apartado 668, Zona 1, *Panama.*

PARAGUAY — Paraguayan Red Cross, calle André Barbero y Artigas 33, *Asunción.*

PERU — Peruvian Red Cross, Jiron Chancay 881, *Lima.*

PHILIPPINES — Philippine National Red Cross, 860 United Nations Avenue, P.O.B. 280, *Manila D-406.*

POLAND — Polish Red Cross, Mokotowska 14, *Warsaw.*

PORTUGAL — Portuguese Red Cross, Jardim 9 de Abril, 1 a 5, *Lisbon 3.*

RUMANIA — Red Cross of the Socialist Republic of Rumania, Strada Biserica Amzei 29, *Bucarest.*

SALVADOR — Salvador Red Cross, 3a Avenida Norte y 3a Calle Poniente 21, *San Salvador.*

SAN MARINO — San Marino Red Cross, Palais gouvernemental, *San Marino.*

SAUDI ARABIA — Saudi Arabian Red Crescent, *Riyadh.*

SENEGAL — Senegalese Red Cross Society, Bld. Franklin-Roosevelt, P.O.B. 299, *Dakar.*

SIERRA LEONE — Sierra Leone Red Cross Society, 6 Liverpool Street, P.O.B. 427, *Freetown.*

SOMALI REPUBLIC — Somali Red Crescent Society, P.O. Box 937, *Mogadiscio.*

SOUTH AFRICA — South African Red Cross, Cor. Kruis & Market Streets, P.O.B. 8726, *Johannesburg.*

SPAIN — Spanish Red Cross, Eduardo Dato 16, *Madrid, 10.*

SUDAN — Sudanese Red Crescent, P.O. Box 235, *Khartoum.*

SWEDEN — Swedish Red Cross, Artillerigatan 6, 10440, *Stockholm 14.*

SWITZERLAND — Swiss Red Cross, Taubenstrasse 8, B.P. 2699, 3001 *Berne.*

SYRIA — Syrian Red Crescent, Bd Mahdi Ben Barake, *Damascus.*

TANZANIA — Tanganyika Red Cross Society, Upanga Road, P.O.B. 1133, *Dar es Salaam.*

THAILAND — Thai Red Cross Society, King Chulalongkorn Memorial Hospital, *Bangkok.*

TOGO — Togolese Red Cross Society, 51, rue Boko Soga, P.O. Box 655, *Lomé.*

TRINIDAD AND TOBAGO — Trinidad and Tobago Red Cross Society, 48 Pembroke Street, P.O. Box 357, *Port of Spain.*

TUNISIA — Tunisian Red Crescent, 19, rue d'Angleterre, *Tunis.*

TURKEY — Turkish Red Crescent, Yenisehir, *Ankara.*

UGANDA — Uganda Red Cross, Nabunya Road, P.O. Box 494, *Kampala.*

UNITED ARAB REPUBLIC — Red Crescent Society of the United Arab Republic, 34, rue Ramses, *Cairo.*

UPPER VOLTA — Upper Volta Red Cross, P.O.B. 340, *Ouagadougou.*

URUGUAY — Uruguayan Red Cross, Avenida 8 de Octubre, 2990, *Montevideo.*

U.S.A. — American National Red Cross, 17th and D Streets, N.W., *Washington 6,* D.C.

U.S.S.R. — Alliance of Red Cross and Red Crescent Societies, Tcheremushki, J. Tcheremushkinskii proezd 5, *Moscow W-36.*

VENEZUELA—Venezuelan Red Cross, Avenida Andrés Bello No. 4, Apart. 3185, *Caracas.*

VIET NAM (Democratic Republic) — Red Cross of the Democratic Republic of Viet Nam, 68, rue Bà-Trièu, *Hanoi.*

VIET NAM (Republic) — Red Cross of the Republic of Viet Nam, 201, duong Hông-Thâp-Tu, No. 201, *Saigon.*

YUGOSLAVIA — Yugoslav Red Cross, Simina ulica broj 19, *Belgrade.*

ZAMBIA — Zambia Red Cross, P.O. Box R.W.1., Ridgeway, *Lusaka.*

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